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STUDY PROJECT

A MANAGED CARE MODEL FOR THE MILITARY DEPARTMENTS

BY

Colonel Douglas A. Braendel, MS
Senior Service College Fellow
Department of Health and Human Services

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SENIOR SERVICE COLLEGE FELLOWSHIP PAPER

A MANAGED CARE MODEL
FOR
THE MILITARY DEPARTMENTS

A FELLOWSHIP PROJECT

by

Colonel Douglas A. Braendel, MS

Office of Prepaid Health Care
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201
15 May 1990

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ABSTRACT

AUTHOR: Douglas A. Braendel, COL, MS

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The proportion of the Operations and Maintenance appropriation being utilized for medical care in the three military departments is increasing. Two major forces are causing this. While the nation is experiencing steadily increasing health care costs, well above general inflation levels; the defense department is compelled to cut budget outlays. The result is extreme pressure on the military medical community to bring under control these escalating costs while continuing to provide quality health care to the beneficiary population. This study seeks to examine the current health care cost crisis and its effect on the nation's employers, of which the Department of Defense is one of the largest. It explores the historical trends and the current government and employer responses. One of the most promising concepts for managing health care is the emergence of managed care and most specifically the health maintenance organization (HMO). The basic concepts of managed care as practiced by HMOs are examined and compared with the management and financing of the military health services system including its CHAMPUS option. Finally a managed care model is presented, which if installed by the military departments, is expected to change the basic system of financing at the local installation level, reorganize the delivery of primary health care to promote better access and continuity, and institute much needed utilization controls to assure that care provided by any health care provider within military facility catchment areas is necessary and appropriate.

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A MANAGED CARE MODEL
FOR THE MILITARY DEPARTMENTS

PREFACE

Although not the most "burning" issue yet for individuals, the steadily increasing cost of this nation's health care system is rapidly approaching the highest priority for the major payers; government at all levels and employers who together pay the vast majority of health care bills today. From the employers' perspective, it is their number one concern when positioning themselves to compete in the world marketplace.¹ Government at all levels is struggling with the development of solutions which could be implemented, given the present political environment. Congressman Jim McDermott (D-Wash), who is a physician and a former member of a Peer Review Organization staff, recently forecast a dramatic change in the United States' health care system within the next decade. He said that the system is "in real trouble" and that the payers "will force change." He said that both government and the private sector "must stop trying to shift costs and begin to control costs."² It is well known that health care costs have increased over the last decade at a rate far exceeding the general rate of inflation, and that these costs

represent a greater and greater proportion of the nation's Gross National Product.

Within the military departments this phenomenon has been exacerbated by the recent reductions in the defense budget. Since 1985, the Army budget has been declining yearly when measured in constant dollars. Since the Army Medical Department must obtain its personnel and material resources from the civilian sector, it has not been isolated from the major cost escalation affecting the total economy. As a result, the Army Medical Department has been absorbing a larger and larger proportion of a steadily shrinking budget. Clearly something must be done to attenuate this situation. Pressure has been building at all levels for the Department of Defense health care managers to solve the problem.

In the view of many major employers, managed care is the only currently viable solution to the cost dilemma. Major corporations have been encouraging, cajoling and even mandating that their employees join Health Maintenance Organizations (HMO) , Preferred Provider Organizations (PPO) or one of the other managed care organizations and have required indemnity companies to install aggressive utilization management programs. As a result of this trend, and in the absence of a currently acceptable national health insurance plan, it has been suggested that

"by the year 2000, most Americans will belong to an HMO or other fixed-fee medical plan."³

For many outside observers the military health services system resembles a health maintenance organization. The employer provides prepayment in the form of an annual budget and the beneficiaries (members) can use the system with little or no copayment. The providers are salaried. However, when one looks at the method of delivering services, utilization management practices, the management of the "open" option known as CHAMPUS, and especially the basis of developing and executing the operating budget; it becomes readily apparent that there are some major differences. This paper is intended to examine those differences and to ascertain if managed care practices as implemented by successful health delivery organizations, could help in controlling military health care costs as they apparently have for major employer payers.

In order to examine and evaluate the current "state of the art" managed care practices, I decided to select several successful health maintenance organizations and to examine their operations. All of these organizations are federally qualified and were considered by federal regulators to be well managed. As a comparison, I selected three community based Army Medical Department Activities providing health care to active duty families and retirees

and their families. I visited each of the nine organizations interviewing the medical directors, administrators and other staff members as necessary. All of the HMOs were either staff or group models which most closely resemble the military "staff" model. I spent a full week with one HMO, participating in their regular staff and utilization review meetings and interviewing each of the staff representing utilization management, quality assurance, member education and delivery system development.

I want to thank the many people of the following organizations who helped me gather my data: Kaiser Foundation Health Plan of the Middle Atlantic States, Peak Health Plan of Colorado, Johns Hopkins Health Plan, Group Health Association, Columbia-Freestate Health System, and HealthCare Corporation of America. Also, I wish to thank the commanders and staffs of the Medical Department Activities at Fort Carson, Colorado, Fort Meade, Maryland and Fort Belvoir, Virginia.

Based upon the information gathered from the above organizations, extensive literature review and attendance at meetings and seminars of such organizations as the Washington Business Group on Health, American College of Healthcare Executives, American Managed Care and Review Association and the American Association of Preferred

Provider Organizations, I have developed a proposed model which I believe has the potential to apply appropriate managed care methods to enhance access, improve quality and control costs within the Department of Defense Health Services System.

PART I. THE MOUNTING HEALTH CARE COST CRISIS

CHAPTER 1. HISTORICAL TRENDS

During the 1950's and earlier, health care cost inflation roughly paralleled the overall inflation rate. During the period from the end of World War II to the mid-1960's federal government policies encouraged and supported with resources increases in inpatient hospital capacity and numbers of physicians. However, with the advent of Medicare and Medicaid in 1965 health care costs began to escalate. In the 25 years between 1960 and 1985 national health expenditures grew from \$26.9 billion to \$423.8 billion.⁴ As a significant additional segment of the population received financial assistance for personal medical costs, utilization increased significantly. In addition, medical technology has virtually exploded with diagnostic and treatment modalities advancing every day. There has been some question whether all of the new technology represents true medical advances and is really beneficial to the patient. There is no doubt that organ transplants have extended the lives of many people, albeit at a large cost, but some technologies may have been applied before adequate testing had been completed. A recent study in Seattle reports that a widely used technique for electronic monitoring of a fetal heart during delivery is "no more effective than a stethoscope in

detecting fetal distress."⁵ The study director went on to say that obstetricians will probably continue to use the technique to avoid possible malpractice claims.

A very large portion of the increase in costs is due to inflation within the economy as a whole. However, during most of the past 25 years inflation of medical services has far outpaced the cumulative increase in the Consumer Price Index. For example, hospital costs have risen at a rate 32% higher than the all items CPI from 1967 to 1986.⁶

Another popular view of the historical trend is to examine medical costs as a proportion of the Gross National Product (GNP). Since the early 1970's medical costs have grown from under 8% to over 12% of the GNP.⁷ Based upon the reactions of the major payers, we may be approaching the point at which further growth is no longer acceptable. How do health care expenditures in the United States compare to those of other industrialized countries? In 1986 United States health care spending consumed 11.1% of the Gross Domestic Product with Sweden, the closest "competitor," with 9.1%. The United States per capita spending in the same year exceeded the runner-up, Canada, by 41% and our major economic competitor, Japan, by 131%.⁸

Contributing to the cost crisis is the increasing supply of physicians per capita in the United States. The

American Medical Association now predicts that by the year 2000 there will be a surplus of 189,000 full-time equivalent physicians.⁹ This projection assumes the current rate of utilization of medical services adjusted for age and sex of the projected population. It is suggested that as the per capita supply of physicians increases, utilization of medical services per capita also increases thereby driving up total costs. At the same time prices do not appear to decline as macroeconomic theory would predict.

CHAPTER 2. EFFECT ON THE MILITARY HEALTH SYSTEM

During the past 25 years the military departments have experienced many changes. Probably the greatest change affecting health care delivery was the decision by our national leadership to adopt an all volunteer force. While the predominantly drafted armed forces were composed of mostly single men and women, the all volunteer force included a much larger number of family members, thereby significantly increasing total beneficiaries. This change occurred mainly during the 1970's. In addition, the number of military retirees increased at a greater rate than previously due to the larger career force which had entered active duty during World War II and the Korean War. The dawn of the 1980's brought a new Republican administration and significantly increased defense budgets. Within the context of an expanding military force and dollar resources, the increases in health care costs were not as noticeable. During this period, with the exception of the Navy, the defense medical establishment shared the military manpower increases. However, with greater numbers of retired members, the demand for health care increased at a greater rate than the capability of the military facilities and staff to provide it.

Since the late 1950's the Department of Defense (DoD) has provided medical care to those who are unable to gain

access to a military medical facility through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This is a package of benefits roughly equivalent to the Blue Cross/Blue Shield high option. At first, the cost of CHAMPUS to the armed forces was relatively low, but as demand for medical services began to outstrip the capacity of the military facilities and personnel to provide the care, more and more beneficiaries opted to use their CHAMPUS benefits. Until 1987, CHAMPUS claims were paid by the Office of the Secretary of Defense and were not a major concern of the individual departments. As a result there was no direct cost to the military departments if medical facilities referred patients to the civilian community under CHAMPUS when they experienced shortages in providers or budget authority. With declining defense budgets in the late 1980's more and more medical care was shifted to CHAMPUS as demand outstripped the medical departments' capacity. The Secretary of Defense found himself returning to the Congress late each fiscal year with a request for additional funding to pay outstanding bills from CHAMPUS providers.

In response the Congress directed that, beginning in 1988, the individual military departments would receive their CHAMPUS funding and be responsible for paying their own bills. This placed the responsibility for funding the

departments' direct care systems and CHAMPUS under the same manager. Also, beginning in 1988 CHAMPUS reimbursements to hospitals were made based upon Diagnostic Related Groups (DRG) as opposed to billed charges. This became possible when legislation was passed making participation in Medicare contingent upon accepting CHAMPUS patients at DRG rates. A reduction of approximately \$150 million was realized for the Department of Defense in 1988.

Another attempt at reducing costs was a DoD directive to combine the facilities of several hospitals and clinics of the three military departments under one command when those facilities were in close geographic proximity and served a similar beneficiary population. Such organizations were established in San Antonio, Texas, the Delaware Valley and in the San Francisco Bay area. The concept was to place all military medical resources in a region under the direction of one department to reduce overhead and share scarcities. Only in San Antonio were financial resources actually transferred from one department to another with the Air Force taking responsibility for funding the Army's Brooke Army Medical Center. After three years of operation the Joint Military Medical Command in San Antonio has not demonstrated a lower cost of operation.

The medical budget is initially developed and presented to the Army leadership as an integrated part of the total Army budget. Projected inflation is not added until the budget is ready to be presented to the Secretary of Defense and then each component is increased by the projected all-items CPI amount. Therefore, each year the Army Medical Department must attempt to convince the leadership that the combined CPI inflation rate will not be sufficient to maintain the level of services required by the beneficiary population due to the higher level of medical commodity price escalation. Often, a budget is presented to the Congress which is inadequate to provide the minimum level of services required. Fortunately, in the past several years the Congress has increased the medical portion of the budget to better align resources with requirements.

CHAPTER 3. GOVERNMENT AND EMPLOYER RESPONSES

During the early 1970's there were many proponents of a national health insurance program. It was felt that by providing equal access for people at all income levels health care costs could be controlled. At that time corporate America joined with provider organizations to decry national health insurance comparing it to the British system which was then characterized by long waits and substandard care. Major industries did not have a large number of covered retirees and medical cost did not appear to be excessive.

Subsequent government efforts included a price and wage freeze by the Nixon administration and an aggressive cost containment campaign waged by the Carter administration. Probably the most effective measure instituted by the federal government has been the Medicare Prospective Payment System (PPS) which became fully operative in 1987. This method of reimbursing hospitals for inpatient care replaced the former reasonable cost basis. Basically, all patients are classified into one of over 400 diagnosis-related groups (DRG) with a fixed reimbursement for each group. It is estimated that over the three years between 1986 and 1988 Medicare saved \$68 billion, although no one really knows what the cost of Medicare would have been without PPS.¹⁰

One adverse impact of this revised inpatient reimbursement methodology has been a major increase in costs of ambulatory care. A significant amount of medical care previously performed in hospitals on an inpatient basis is now provided in an ambulatory setting. Much of this ambulatory care remains in hospitals while some is now provided in physicians' clinics and free standing surgical centers. Since Medicare still uses the customary-prevailing-reasonable (CPR) charge method for outpatient reimbursement, these costs have continued to soar. Current initiatives by the federal government include attempts to install caps on total Medicare expenditures and the installation of a variant of the Harvard developed resource-based relative value scale (RBRVS). This system is not designed to reduce costs overall, but to increase rewards to those providers practicing cognitive medical skills while reducing fees for more invasive treatment, such as surgery. It is hoped that this realignment of reimbursement will encourage more medical school graduates to enter primary care specialties and avoid, to some extent, the over supply of specialists otherwise expected.

For the past decade employers have been looking to managed care to stem the cost increases. During the first half of the 1980's enrollment in capitated plans grew at an annual rate of 20% per year.¹¹ Prepaid health care plans

received a boost in 1973 when the Congress passed legislation overriding state laws which had previously either deterred or outright banned such organizations. In addition, the legislation included a mandate for employers to offer at least one federally qualified health maintenance organization (HMO) plan to their employees as an alternative to indemnity plans. Major resistance from organized medicine was overcome and today these plans, as well as many new variants, are proliferating in most sections of the United States. Many are now saying that the fee-for-service arrangement will be all but extinct by the year 2000.¹² Mason Irving, manager of Arthur D. Little's health care practice suggests that employers will increase their use of managed care plans. With 30% of U.S. workers in managed care today, Irving believes that half of the population of the United States will be in managed care by 1995.¹³ The government is doing its part by encouraging HMOs to contract with HCFA to provide prepaid managed care to Medicare beneficiaries. To date almost 2 million of the estimated 33 million Medicare beneficiaries are enrolled in HMO's. The current and expected growth in managed care is due to the perception of both government and business, that managed care represents better cost control and better quality than the fee-for-service alternative. Congressman McDermott stated that "studies

have shown that a well run managed care system can provide better quality care than a fee-for-service system at 25% less cost. Managed care offers real hope for a way to break the cycle of expanding access and controlling costs."¹⁴

However, corporate America is quickly running out of patience. Several large employers instituted major managed care programs with immediate results. Unfortunately, the cost savings appear to have been one time events as even managed care costs continue to increase. A survey by A. Foster Higgins & Co., found the average cost for employees in health maintenance organizations jumped 16.5% from 1987 to 1988, lower than the 20.4% increase for medical insurance but still far above the national inflation rate.¹⁵ Unable to cope with increases such as these, some major firms, along with a number of the nation's largest labor unions, are now calling for the federal government to step in with national health insurance. Companies, such as Ford Motor Co., A.T. & T., Du Pont Co., and Eastman Kodak Co., have joined with several national unions to form a group called the National Leadership Coalition for Health Care Reform.¹⁶

Even the major medical journals have begun to step into the cost crisis fray. Dr. Nicholas E. Davies and his colleague Louis Felder of Atlanta wrote in the New England

Journal of Medicine, "We believe that the American healthcare system, especially its costs, is out of control."¹⁷ The editor of the Journal of the American Medical Association, Dr. George D. Lundberg, criticized the medical profession for having too many "money grubbers" and too few "altruistic missionaries."¹⁸

PART II. THE MANAGED CARE MODEL

CHAPTER 1. BASIC CONCEPTS OF MANAGED CARE

SECTION A. HEALTH CARE DELIVERY

Although the term "managed care" is used often and by many, few are able to define it. It is often described as a spectrum of organizations and financing arrangements ranging from managed indemnity products to the staff/group model HMO. Managed indemnity describes a pure insurance product with the addition of some form of prospective utilization review and often arrangements with individual providers who accept assignment. As we move across the spectrum from managed indemnity we find Preferred Provider Organizations, Open-ended Health Maintenance Organizations, Exclusive Provider Organizations, Individual Practice Association (IPA) HMOs and finally the staff or group model. To make matters more confusing, few of these models are "pure"; many variations and permutations exist.

After searching the literature and collecting materials from the various managed care trade associations I discovered that no one had a definition of "Managed Care." I have constructed my own definition which, I believe, would include all parties who espouse to conducting or regulating managed care, but would, I am sure, be unacceptable to those toward the group/staff model end of the spectrum. My definition of managed care includes all

activities performed by payer, insurer or health care provider organizations to assure delivery of appropriate and quality health care to beneficiaries. These activities include, but are not restricted to; quality assurance, utilization management, peer review, provider selection, patient cost sharing, capitation and other provider incentive plans. Organizations involved in managed care may use one, all or any combination of these activities to improve the quality and cost effectiveness of health care delivery.

Now that "managed care" is defined very broadly, I intend to concentrate my description of the basic concepts toward the right of the spectrum; that is, care provided by organizations which manage access, coordinate care for the members and have formal programs for the management of both utilization and quality. Because the current system of military health delivery most resembles a staff or group model HMO, I will describe the basic concepts inherent in well managed staff/group model HMOs.

Managed care is always characterized by a fixed enrollment. Since the source of revenue is a periodic premium paid for individual or family membership, there is a record of precisely what the HMO's membership is at any given time. Based upon that membership, an appropriate delivery system is developed. Normally, members are asked

to choose a specific clinic location where they would like to receive their primary care services. In most cases, they are also asked to choose a particular physician. This is important as this physician usually serves in a "gatekeeper" role. In reality, the "gatekeeper" physician is responsible for coordinating all of the medical care to be received by his or her patients. Primary care physician specialties include general internal medicine, pediatrics and family practice. In some plans, a female member may utilize a gynecologist as her primary provider; however, this is uncommon. Normally, adults choose an internist for themselves and a pediatrician for the children. If family practitioners are available families may choose that provider. A change from one primary care physician to another at any time is permissible. The most common staffing ratio is approximately one primary care provider (PCP) per 1,600 members. If family practitioners perform routine deliveries, a more appropriate ratio would be 1:1,400.¹⁹ The six group/staff HMOs which I surveyed ranged from ratios of 1:1,300 to 1:3,000 with most in the range of 1:1,400 to 1:2,000. In most cases, it was dependent upon the individual provider's capabilities and the demographics of his or her panel of members. All of the plans monitored measures of patient access so that if members were found to be waiting excessive lengths of time

to receive care, action would be taken to adjust the provider's number of enrolled members or to assist the provider in managing his/her patient demand.

Extensive use is made of primary care provider extenders in most plans. Depending upon what is customary and accepted in the local area, nurse practitioners and/or physicians' assistants provide direct patient care under the general supervision of physicians. Using extenders increases the ratios noted above by shifting the more routine care from the physicians.

In addition, almost every plan surveyed utilized registered nurses in the role of the triage or advice nurse. Members are encouraged to make initial contact by telephone for all medical problems. For situations which can not be handled by making a routine appointment, but for which the member needs some immediate care or advice, the caller is referred to a registered nurse. These situations are spelled out to the receptionist/appointments clerk within a protocol developed by physicians of the plan. Utilizing another set of protocols, the advice/triage nurse listens to the member's problem, provides immediate feedback and, if necessary, arranges for an appointment with a provider. All advice is recorded on an encounter form, reviewed as part of the quality assurance program and posted to the patient's medical record. Most plans reserve

at least 40% of their daily PCP appointments to be filled by the advice nurse. For Mondays, and especially Tuesday after a long weekend, some plans reserve all appointments to be filled by the nurse. Alternatives to same day or next day appointments are various regimens of self treatment or routine diagnostic tests to rule out urgent problems.

With PCPs responsible for all care, they usually attempt to handle as much as possible in the primary care setting. If specialty care is indicated, the physician will refer the patient to an appropriate specialist within the plan if available; or to a contracted specialist outside of the organization. In all cases the consult request is very specific. The term "Evaluate and treat as necessary" is not usually found on these consults. Once the specialist has evaluated the patient, he/she contacts the PCP to determine the next step in the evaluation/treatment process. In most capitated plans, specialists must request approval from the PCP before conducting or ordering high cost diagnostic tests. Should definitive treatment be required (inpatient or outpatient) the PCP is central to the development of the treatment plan.

All of the plans surveyed require monthly premiums to cover a majority of the costs of health care delivery. The

greatest part of the premium dollar is commonly paid by the member's employer; however, more and more employers are shifting some of this cost to their employees. In approximately half of all HMO plans, patients are required to pay a small copayment when receiving care and in some cases when obtaining a prescription drug.²⁰ These are usually quite small (\$5 to \$10 maximum) for routine visits; however, several plans charge a \$25 copayment for the use of an emergency room. This is felt to discourage inappropriate use of the emergency room and is better, from a member relations viewpoint, than retroactively denying reimbursement to members for a visit to the emergency room which is determined to be medically unnecessary. Most plans do not operate their own emergency rooms and must contract or pay billed charges. Prescription drugs are not always an included benefit; in those cases where they are the plan may operate its own pharmacy, contract with an inhouse consignee or pharmacy chain, or reimburse patients for their prescriptions after a deductible.

From the point of view of the beneficiary, the military health services system resembles a giant open ended or point of service HMO. The Defense Enrollment Eligibility Report System (DEERS) is an automated enrollment database containing the names, addresses and eligibility category of over nine million beneficiaries. Enrollees may obtain

medical care at any uniformed service treatment facility. Certain categories of beneficiaries are also eligible to seek care from any qualified provider with reimbursement from CHAMPUS assuming the care is a covered CHAMPUS benefit. Those seeking reimbursement must pay a yearly deductible and either 20 or 25 percent copayments depending on the category of beneficiary. Medical care for active duty members of the uniformed services must be provided by the direct care system at military treatment facilities or through non-defense providers with reimbursement by the defense department. All other categories of beneficiaries are provided care in military treatment facilities on a "space available" basis. If the care is not available or timely they must obtain care outside of the military facility. Generally those under 65 years old are eligible for CHAMPUS while most older beneficiaries are eligible to use their Medicare benefits.

Military medical care is clinic based with initial access through a general outpatient clinic or an active duty "troop" clinic. Primary care specialties include family practice, pediatrics and general practice. Access to specialists, including general internists, is by referral from the general outpatient clinic. Few registered nurses are utilized in the primary care setting. Patients with medical problems which they consider urgent

usually come into the clinic on an unannounced walk-in basis. After vital signs are checked by a medical technician, the patient is seen by a physician or a physician's assistant. Except for family practice, patients cannot formally select a physician; however, most pediatric clinics informally assign their patients to a specific pediatrician. The Army embarked in 1985 on an ambitious program to obtain sufficient family practitioners so that every Army family could have its own physician. Due to budget constraints and a shortage of trained family practitioners this goal has not yet been attained.

With the resulting lack of continuity of care many beneficiaries choose to use their CHAMPUS benefits and obtain an internist or family practitioner outside of the military clinic. For people with chronic medical conditions it is unsatisfying to be forced to periodically access the system and deal with a different physician each time. Except for the addition of family practice and the increased utilization of physician's assistants, the general method of delivering primary care in the Army has not changed since the end of the draft. At that time the ability to draft general practitioners coupled with fewer active duty family members permitted relatively easy access to primary care. Unfortunately, the military departments are faced now with an much larger beneficiary population

without a draft to obtain the needed primary care physicians. Increasing the number of family practitioners will solve this problem; but, not within the next few years.

Although service areas are not defined in the same way that HMOs define them, each inpatient military treatment facility is generally responsible for a catchment area. This is an area roughly described as that within a forty mile radius around the facility. The area is refined to specific zip codes and takes into consideration natural barriers. Beneficiaries who live within the catchment area must obtain prior authorization for any inpatient care to be reimbursed under CHAMPUS. This is not precertification in the normal sense, but is actually an opportunity of first refusal. The commander of the military medical treatment facility usually does not question the necessity or appropriateness of the proposed admission, but bases the approval on the lack of capability of his or her military facility to provide the care. If the patient's zip code is included in any other catchment areas, those facilities are contacted to assure that none of them can provide the care; however, currently there is no formal method for documenting this. Under current regulations CHAMPUS eligible patients are not required to accept an offer of inpatient treatment at a facility outside of the catchment

area. Therefore, patients in Colorado Springs can demand a certificate of non-availability even if the care is available at Fitzsimons Army Medical Center in Denver, a two hour drive away. A copy of the approved certificate of non-availability is necessary for the fiscal intermediary to pay the CHAMPUS claim.

SECTION B. UTILIZATION MANAGEMENT

The adoption of utilization management by payers and providers of health care is a relatively recent phenomenon. After many years of inaction on the part of purchasers, they have become particularly active during the last decade in their attempt to influence the rapidly escalating costs of care. In addition to encouraging and even mandating the use of HMOs and PPOs for their employees most employers have jumped onto the utilization management (UM) bandwagon. In the past, this activity was called utilization review and was conducted in hospitals almost entirely on a retrospective basis. Now, more and more, utilization management is conducted by purchasers or indemnity companies and is prospective in nature. Before elective care or diagnostic services are provided, the provider must obtain authorization. In the absence of authorization, the payer may deny payment for the services.

Early in the 1980s Blue Cross plans began to implement pilot programs of preadmission certification. In its first year, Blue Cross/Blue Shield of North Carolina experienced a 37% decrease in hospital days per thousand insured. What was most interesting about this is that the pilot group was not denied a single admission, but achieved this result because of the "sentinel" effect on physician behavior. Knowing that the plan was monitoring requests, physicians

looked for alternatives.²¹ Since that time prospective utilization management has virtually swept the landscape with well over 90% of large corporations either conducting themselves or requiring their insurance carriers to conduct preadmission and concurrent review. In 1984 the Mayo Clinic dealt with one UM program. By 1988, it was working with over 1,000 utilization review plans.²² From 1982 to 1986 the percentage of Blue Cross plans using prior review programs increased from 28 to 95.²³ Many HMOs have used some form of utilization management for years. Most conduct their own programs but recently there has been growth in the number of HMOs contracting with external review firms. This has been spurred, in part, by the desire to move the review farther from the affected providers.²⁴

All six HMOs surveyed have formal utilization management programs. They place their emphasis upon different aspects of UM but in all cases they are convinced that they must control utilization to be competitive. At the same time, they do not serve a captive population. Virtually all of their members are free to change plans at the end of each year, so control of utilization must not alienate the membership. HMOs resemble the typical competitive model; to survive they must provide quality services at a competitive price. To make this a bit more

challenging, much of the cost is covered by a third party who is not directly receiving the services while the patient receiving medical services pays a minimal amount.

Until now most efforts at controlling costs through aggressive utilization management have concentrated on inpatient hospital care. As a direct result, health care providers have sought out and begun to use ambulatory alternatives. Third party payers have encouraged this by adjusting their benefit packages to make it more financially beneficial for patients to seek the most appropriate care in the most appropriate setting. Not unexpectedly, ambulatory care costs have increased considerably. Medicare's PPS contributed to this by restricting the reimbursements hospitals could receive for inpatient care while placing few controls on hospital ambulatory services. Savings in inpatient care have been offset by the cost of increased ambulatory care as well as the cost of the utilization management program itself. Probably the most extensive analysis of overall cost effectiveness of utilization management was done by Thomas Wickizer and two associates. Their study found that utilization management decreased inpatient days by 11 percent and total medical expenditures by 6 percent. They also cautioned that these were one time reductions. Employers with relatively high rates of admissions (more

than 125 admissions per 1,000 beneficiaries per year) would probably realize even greater cost savings.²⁵ According to a recent Congressional Budget Office study the median military catchment area experienced 219 admissions per 1,000 active duty dependents.²⁶

Each of the surveyed HMOs has utilization management programs in place. All but one requires preadmission certification and that one follows all admissions with aggressive concurrent review. Preadmission certification is based upon nationally recognized criteria usually modified by the plan physicians. All plans have a list of procedures and diagnoses which would normally indicate ambulatory care. Admissions requested for one of these conditions are denied in the absence of complicating factors. If the admitting provider does not agree with the registered nurse applying the criteria, he/she is referred to a physician. In many plans, this is the Medical Director or Associate Medical Director. Specialists are maintained on retainer to assist the plan medical director in cases which can not be resolved at that level. These situations occur very rarely as those in the "gray" area are almost always resolved in favor of the admitting physician. At the time of admission, a maximum length of stay is approved by the utilization nurse; again, based upon standard criteria. Some plans approve a very short

length of stay with additional days approved during the concurrent review process. Others set the length of stay at a level suggested by DRG criteria or other national or regional average.

Concurrent review is again conducted by registered nurses. All but one of the plans surveyed accomplished this by on site reviews of the inpatient records. Specific standard criteria are applied for each day of hospitalization to assure that the patient requires that level of acute care setting. All of the plans have contracts with alternatives, such as skilled nursing facilities and home health care agencies. The concurrent review nurse will contact the attending physician when it appears that the treatment plan does not meet acute hospital care criteria and negotiate alternatives. At the same time the nurse will contact the contracted nursing facility or home health care agency and alert them. Again, the medical director or associate medical director is available to intercede in cases where the attending physician does not agree with the criteria. In most cases, the hospital is provided the criteria and is notified by the concurrent review nurse when a plan patient does not meet criteria. Based upon the installation of new nationally recognized criteria, one plan denied payment for over 1,000 days of hospital care in 1989 for a savings to

the plan of \$850,000. Savings are expected to be less in 1990 as hospitals and physicians begin to react more quickly toward working with this plan to arrange alternatives to acute care hospital days. Retrospective review is still a valuable tool, but not considered as effective in changing behavior. Also, from the point of view of the contracted providers, concurrent review is preferable to the retrospective denial of reimbursement.

With indemnity companies embarking on aggressive utilization management of inpatient care and the resulting shift to the ambulatory setting, HMOs are now looking carefully at the utilization management of ambulatory care. The majority of the plans surveyed have developed programs to preauthorize high cost ambulatory procedures and to review prospectively referrals to specialists outside of the plan network. Even PPOs are beginning to recognize that thresholds must be set for ambulatory procedures. They recommend a limit of \$200 to \$300 per diagnostic or treatment episode above which preauthorization is required.²⁷ In most cases this preauthorization exempts certain routine referrals and is done by a department or clinic chief. In one medical group examined, these requests are brought weekly to the medical director by the clinic chiefs where they are discussed in a conference setting with the final decision by the medical director.

This includes requests by contracted specialists to admit patients, perform high cost diagnostic procedures or ambulatory surgery. As in inpatient utilization management, such review generally results in a "sentinel" effect and requests are infrequently denied after the program matures.

Case management for high cost cases is used by all of the plans surveyed. Case management refers to services, usually performed by registered nurses, which arrange multiple health care plan options when a serious illness is diagnosed. Most plans have developed general criteria which alert utilization nurses to cases which should be closely managed. Case management requires the cooperation of the patient, the physician and usually the patient's family to derive the maximum benefit. The case manager works closely with the physician, social worker, utilization management, the patient and family to develop and implement a management plan for the patient. The benefits are twofold. The HMO can save significant resources and the patient and family are provided personal attention and assistance in dealing with catastrophic illness or injury.²⁸ In addition, the physician is relieved of a burden which he is usually not equipped to handle.

The most recent area to receive attention is that of ambulatory clinic care. It is recognized by group/staff

HMOs that it is in the clinical practice of medicine that organized medical group practices have an advantage in the management of utilization. Pioneering work has been started in developing practice guidelines or parameters to use in evaluating care provided in the ambulatory setting. Several medical specialty organizations have been working on guidelines for some time while others have not yet begun. Various utilization management vendors are marketing automated programs designed to assist HMOs and PPOs in reviewing the care provided in the physician's office. The American Medical Association's Office of Quality Assurance, established in 1988, is working to encourage the development of practice parameters. According to Dr. John T. Kelly, Director of Quality Assurance, AMA, 21 national medical specialty societies have developed practice parameters or guidelines with ten other societies planning to begin. After Medicare began to use guidelines established by the American College of Cardiology, the implantation of pacemakers declined by 25 percent. The AMA position is that these guidelines be developed by national physician organizations and be public domain. They should not be developed by payers or by government.²⁹ Although most of the HMOs surveyed did not have published practice guidelines, they did utilize encounter forms to identify outliers in the use of

laboratory services and referrals to specialists. Based upon the interest generated at the 1989 annual meetings of the American Association of Preferred Provider Organizations and the American Managed Care and Review Association this will be the next major application of utilization management in managed care organizations.

Review of the three Army Medical Department Activities (MEDDAC) found utilization management to be in much more rudimentary stages. No definitive direction has been provided by the "corporate" headquarters, U.S. Army Health Services Command, in San Antonio, Texas. Each MEDDAC has a utilization review function in place with reviews accomplished based on varying criteria. Generally, all Army utilization review programs are expected to comply with the requirements for hospitals of the Joint Commission on Accreditation of Healthcare Organizations. One of the MEDDACs has developed a draft list of procedures which should be done in an ambulatory setting. Another MEDDAC has an informal program of preauthorization for admissions to civilian hospitals under CHAMPUS. Concurrent review of mental health cases is conducted at one of the MEDDACs. Formal preauthorization of admissions to military hospitals is not evident at any of the MEDDACs and there appears to be no program of concurrent review in a formal sense. Department physicians routinely review inpatient status,

but there was no evidence of the use of written criteria for admission, length of stay, or appropriateness of the acute care setting. All of the MEDDACs are aggressive in the development of formularies to stock the appropriate drugs given the scope of practice of their providers. Prescribing drugs not on the formulary requires formal review and approval of the department chief or medical director. In one MEDDAC, the medical director reviews all prescriptions daily to identify those with a high cost which are inappropriate based upon the diagnosis.

Since individual MEDDACs are financed and staffed on the basis of volume of care provided, rather than capitation, there is little incentive to look for and eliminate unnecessary care. At the same time, most of the individual providers are salaried with no real incentive to overutilize services. However, they know that the patient has little or no out of pocket costs and that the organization's budget depends upon the number of admissions and clinic visits. Recently a newly authorized program has placed fee-for-service providers in the military treatment facilities. There have been some indications that utilization of both ambulatory and inpatient services has increased where these providers have been employed. At one MEDDAC catchment area the use of allergy services increased by over three times with the addition of fee-for-service

(FFS) providers with no patient copayment required. Primary care providers at that MEDDAC referred patients with allergy symptoms to the FFS allergists on an open consult with no following management of the utilization of those services.

A recent initiative by the Assistant Secretary of Defense (Health Affairs) is using the already existing contracts between the Health Care Financing Administration (HCFA) and the Peer Review Organizations (PRO) to begin reviews of CHAMPUS care. In selected areas and for selected procedures, the PROs are conducting precertification reviews for CHAMPUS. It is expected that this contract will be extended to additional areas and procedures if, as hoped, the evaluation shows cost reductions due to reduced utilization.

SECTION C. QUALITY ASSURANCE

Assuring the delivery of quality care in an HMO is key to a successful plan. One of the most compelling arguments against the concept of prepaid health care has been that paying the provider on the basis of capitation rather than actual services provided would lead to the withholding of necessary care to the detriment of the plan member. To meet this objection and to protect the patients, the HMO Act of 1973 included strict requirements for quality assurance (QA). Federally qualified HMOs must have formal programs with demonstrated effectiveness. The program must include the following elements; an on-going program including an active QA committee and a systematic process, a QA methodology which stresses health outcomes rather than processes, peer review, systematic data collection, and procedures for appropriate remedial action.³⁰

In many respects, the staff or group model HMO is in a better position than FFS to assure quality care is delivered. The physician group is closed and care is concentrated in fewer sites. The providers have more of an opportunity to meet and establish standards of care and algorithms which result in high quality care. In addition the QA program can act as the ultimate patient advocate, seeking evidence of compliance with the established standards.³¹

Most of the surveyed HMOs manage both their Quality Assurance and Utilization Management programs under the Medical Director. In this way, concurrent review nurses are encouraged to identify problems with quality along with utilization. In many cases the control of overutilization reduces risk to the patient and results in better quality. At the same time, patient re-admissions are always reviewed by quality assurance committees to identify possible inappropriate application of utilization criteria.

Managed care organizations are joining major payers in support of increasing medical outcomes research. They are convinced that the knowledge of the medical effectiveness of current diagnostic and treatment procedures will enhance quality while controlling costs. Dr. Paul Ellwood of Interstudy suggests that half of what the medical profession does today is of unverified effectiveness.³² In 1990 the Congress provided the Public Health Service with major increases in appropriated funds to support outcomes research. This program is expected to grow even more.

Quality Assurance within the military direct care system is a very high priority. During the past few years additional resources have been applied to this effort at the corporate as well as the local level. Current programs contain all of the components required of HMOs by federal regulations. However, little of the care received by

military beneficiaries outside of the direct care system is monitored by the DoD for quality. Patients unable to gain access to direct military care are unable to obtain any definitive information from the MEDDAC which might guide them to a high quality CHAMPUS or Medicare provider. There are some exceptions to this. In many Air Force medical facilities a "health care finder" does identify local physicians who will participate in CHAMPUS and whose credentials are reviewed. Patients are given a list of these physicians from which they can choose. Several CHAMPUS demonstration projects have been initiated in which the Department of Defense is involved in the organization of provider networks. In these demonstrations military officials work directly with contractors or networks of providers in monitoring their quality assurance programs. In addition, grievance and appeals procedures are mandatory components of these demonstrations, which will be described in the next chapter.

CHAPTER 2. CURRENT PRACTICE OF MANAGED CARE WITHIN THE MILITARY HEALTH SERVICES SYSTEM

SECTION A. HEALTH CARE DELIVERY AND FINANCING

The Department of Defense operates one large prepaid plan with a point of service or open option for certain segments of its beneficiary population. Active duty members of the uniformed services must utilize the direct care system, with all of their care coordinated by military providers. When appropriate care in a military facility is not available for active duty members, the member is referred to a specific non-military provider with all costs born by the government. This care can be provided by other government agencies; e.g. Department of Veterans Affairs, or civilian providers. Emergency care provided by civilian providers to active duty members is also reimbursed totally by the military departments.

Most other beneficiaries, dependent family members of active duty members, uniformed services retirees and their dependent family members, and survivors of active duty or retired members, are eligible for either CHAMPUS or Medicare benefits. These beneficiaries may choose to obtain covered medical services from any licensed provider whom they choose and will be reimbursed a portion of their costs based upon their CHAMPUS or Medicare benefits packages. For CHAMPUS beneficiaries who require inpatient

services, there is one important restriction. If their home address is within a roughly forty mile radius of a military inpatient medical facility (catchment area), a certificate of non-availability of services must be obtained from that facility. Otherwise, there will be no CHAMPUS reimbursement for those inpatient services. The certificate is generally issued when the hospital does not provide the specific services requested or the current requirements for those services exceed the hospital's capability to provide them in a timely manner. This restriction does not apply to Medicare beneficiaries.

As mentioned before, beneficiaries are enrolled in a worldwide system and may request and receive care at any military treatment facility or former Public Health Service facility, now known as Uniformed Services Treatment Facilities. Commanders of individual medical facilities have only a rough idea of the population their facilities support. When two or more military facilities are in close proximity, beneficiaries tend to "shop" for the best and most responsive care and use multiple points of access. They even begin to maintain their own medical records, carrying them from one facility to another. Beneficiaries living outside of the catchment areas will often drive over one hundred miles to access the military system where the care is free and they feel more comfortable. Some military

retirees move toward the south seeking a warmer climate during part of the year placing unexpected demands upon the facilities where they spend their Winters.

Since military medical facility commanders cannot accurately account for those beneficiaries who use their facilities, the budget and staffing plan is developed using workload as the basis. As in most government programs, the annual budget is a fixed amount. Therefore, the commanders compete for resources on the basis of workload. At the beginning of each fiscal year the dollar and manpower resources are allocated based upon the expected work units to be produced by each facility in the system. During the year adjustments are made; withdrawing funds from those commanders whose workload is falling short of the program and adding funds to those who are exceeding expectations. As can be expected, commanders make every effort to meet or exceed their programmed workload.

Although beneficiaries may access any military treatment facility in the DoD system, the resources are provided independently from the three military departments. Beneficiaries who traditionally receive services from one of the departments may access another department's facilities. By federal statute the departments are prohibited from billing or reimbursing one another for care

provided to service members, their families or retirees of another department.

Until recently the work unit was the Medical Care Composite Unit (MCCU) in which one unit represented an inpatient day of care. Each admission and each live birth was given a weight of 10 and each outpatient clinic visit was given a weight of .3. Although the MCCU was relatively accurate in predicting resource requirements at the worldwide level, it led to inequities and gaming at the local facility level.

In order to overcome some of the problems inherent with this work unit, the Department of Defense has been working on a system incorporating the DRG for inpatient workload and an Ambulatory Visit Group (AVG) for the ambulatory component. These are to be integrated into a single unit which will accurately reflect the resource requirements at the local level. To date, the DRG has been developed with resource based weights using CHAMPUS experience coupled with an interim ambulatory system using different weights for visits to specialty and subspecialty clinics. The Department of Defense is hesitating to convert to a permanent AVG system until HCFA decides which of the more prominent alternative systems it will adopt. In the meantime the hybrid Medical Work Unit (MWU) combining the DRG and interim AVG will be used.

As one can imagine, the current system of budgeting and allocation of resources rewards those who do more. A commander who institutes strict utilization controls within his facility would be cutting his own revenue.

SECTION B. DEMAND FOR PRIMARY CARE

Military beneficiaries who seek medical care or advice for a new medical problem have basically three choices. They can go to the general outpatient clinic (or emergency room after normal hours) and enter the queue. Generally, for this care setting, no appointments are given and patients are seen by a provider on a first-come first-seen basis. A second choice, assuming the patient is not active duty, is to use CHAMPUS or Medicare benefits and seek care with a civilian provider. For CHAMPUS beneficiaries, the copayment is between 20 and 25 percent and the yearly deductible a very low \$50 per individual and \$100 per family. A third choice is to self treat until the symptoms subside or become more acute. Depending upon the ease of access, a function of time/distance to the clinic and the expected length of wait, and the perceived severity of the symptoms, the beneficiary will choose among the three. Unfortunately, at many treatment facilities, the demand for primary care exceeds the capability of the presently configured system to handle it.

At first glance it appears that the system simply does not have enough primary care providers to handle the demand. One major problem appears to be a demand for primary care which for the military health services system exceeds that experienced by the general population. While

the average rate of outpatient visits in the civilian population is five per year per person, active duty dependents average is seven, a difference of 40 percent.³³ There are probably multiple reasons for this. Most young military families are not stationed close to their extended families. Instead of calling home to ask for advice (a long distance call), the military member or spouse will choose to use the "free" (no out-of-pocket) medical benefit. Since the military system does not use the advice nurse to any great extent, the patient usually must go to the clinic for help. Also, the military facilities provide free non-prescription drugs and supplies when required for medical care under the direction of a provider. Free aspirin, throat lozenges, etc. can only be obtained by prescription at most military facilities. Some military families will access the system to obtain these items as they consider them part of their military benefit package.

For HMOs, the open ended product is relatively new. As in the military system, control of non-plan providers is minimal in regard to both quality and cost. Therefore, in order to maximize use of the HMO panel of providers and discourage members from selecting the option to go to outside providers, primary care access is made as convenient as possible while a relatively high cost is placed upon the open option in the form of a deductible.

The military open ended product operates in exactly the opposite way. Access to in-house primary care is difficult and/or time consuming while the low \$50 deductible is little financial deterrent to opt for CHAMPUS, except, perhaps, for the lowest paid military members, retirees and survivors of deceased military active duty and retired members.

SECTION C. CURRENT INITIATIVES

The Department of Defense has been quite aggressive in adopting many managed care tools. Through contracting with managed care organizations and insurance carriers several major initiatives have been launched. All of these initiatives are yet in the demonstration phase. Evaluations of their effectiveness in improving access and controlling costs are not yet complete.

Probably the most ambitious is the CHAMPUS Reform Initiative (CRI). Conceived as a way to enhance medical force readiness by forging partnerships with major health delivery organizations, the initial scope and potential risk of the project was a bit too daunting for most organizations. After CRI was scaled down to a six state demonstration, only one bid for the states of California and Hawaii was received. The fixed price, shared risk contract was awarded to Foundation Health Corporation. Foundation developed provider networks throughout the two states and initiated a "closed panel" product called CHAMPUS Prime. Enrollees are promised increased access and deductibles are waived in return for the enrollees using only the network providers. In addition, preventive services which are not reimbursable under CHAMPUS are provided at no charge. Copayments are reduced to a nominal level when enrollees use the civilian network. The

eighteen military treatment facilities in the region are considered the first choice provider under the CHAMPUS Prime option and the contractor can arrange with the military facility commander to provide appropriate additional resources to the military facility to compensate for shortfalls and allow services to be provided in the direct care system. Enrollees are "locked in" for one year. Registered nurses employed by the contractor are located in each of the military facilities to identify health care needs and arrange for CHAMPUS Prime appointments with network providers when care is not available within the military facility.

The Catchment Area Management (CAM) initiative is similar to CRI except that the focus is on the local catchment areas, rather than across several states, and the networks are organized by the military facility commander rather than by a contractor. In this demonstration, the medical commander is provided with a combined direct care and CHAMPUS budget and is responsible for providing care to all eligible beneficiaries within the total resource levels. He is given latitude to develop benefits packages and must include an enrollment feature in his "preferred plan." As in the CRI demonstration, beneficiaries may choose not to enroll and receive their care in the traditional fashion.

In the mental health area both the Department of Defense and the Army are conducting demonstrations. Each of these attempt to contract for a continuum of care in order to reduce total costs. The Army's Fort Bragg, North Carolina demonstration contract is with the State of North Carolina and is for children and adolescents only. In 1989 the DoD contracted with a mental health utilization management firm to provide intensive case management for all CHAMPUS mental health cases which represent the fastest growing segment of total CHAMPUS costs.

At Fort Drum, New York the Army has developed a military-civilian partnership to provide care to DoD beneficiaries in the Watertown area. Outpatient care is provided by military primary care providers and contracted specialists at the Army clinic. Family members have access to CHAMPUS providers as well. All inpatient care is provided at one of several civilian hospitals in the area. Sufficient family practitioners have been assigned to Fort Drum to care for all active duty members and their families. Military providers are credentialed by the hospitals to provide care within those facilities.

The Office of CHAMPUS has initiated a demonstration which includes home health care and case management. As exists in most HMOs, case management is initiated for serious, long term, costly and incapacitating conditions

with an effort toward coordinating the care and controlling costs. This demonstration is active in the states of Colorado and Washington and in the national capital region. Evaluation is projected for 1991.

CHAMPUS has also contracted with its fiscal intermediary in the Southeast United States to establish health delivery networks in that area of the country. Utilization management and high cost case management have been added. Basically a "health care coordinator" in each military hospital will assist beneficiaries in arranging for care from a network provider. In almost all of these demonstrations, providers are contracted on a discounted fee basis. As mentioned previously, the DoD has contracted with the PROs to conduct utilization management of CHAMPUS inpatient care.

In recognition of the severe primary care access problem, the departments are using the "doc-in-a-box" concept to provide care for acute minor illness through contracts for contractor owned-contractor operated clinics located in areas with the most demand. These facilities (called PRIMUS by the Army and the Air Force) are essentially walk-in clinics which provide comprehensive primary care at a single price per visit. There is no effort to coordinate care by these contracted clinics;

specialist referrals are to the sponsoring military facility.

For several years the military departments and the Department of Veterans Affairs have been engaged in sharing agreements. These agreements are negotiated and executed at the local level and include medical and non-medical support services. An example is the use of the Brooke Army Medical Center MRI by the Audie Murphy Veterans Hospital in San Antonio. The fees are locally negotiated, based upon cost, and payment is made for services provided.

These are only a few of the myriad initiatives which characterize the Department of Defense efforts to utilize managed care concepts. As noted, the evaluations will not be completed for many of these for several years. With the impending military force reductions and expected base realignments the military departments have an excellent opportunity to reorganize the delivery system to make it more responsive and cost effective.

PART III. A MANAGED CARE MODEL FOR THE MILITARY DEPARTMENTS

CHAPTER 1. CATCHMENT AREA HEALTH PLANS

SECTION A. OVERVIEW

The basis for the proposed model is the current Catchment Area Management demonstration now being conducted by the three military departments as opposed to the multi-state model demonstrated by the CHAMPUS Reform Initiative. Health care is generally delivered on a local or regional basis. Even the large national HMOs have organized themselves into regions and give a great deal of autonomy to their regional plan managers. The military counterpart to this is management by catchment area. These catchment areas have already been defined by the DoD with special rules applying to those which overlap with other military catchment areas. Additional catchment area health plans might also be established surrounding ambulatory facilities located at some distance from their parent hospitals. Examples might be clinics at such installations as Carlisle Barracks, Pennsylvania or Aberdeen Proving Ground, Maryland. Catchment areas of the same department which overlap could be consolidated into a single plan. An example of this might be aligning the MEDDACs at Fort Meade, Maryland and Fort Belvoir, Virginia with Walter Reed Army Medical Center in Washington, DC.

Given the complexities of transferring medical facilities from one department to another, it would not normally be advisable to mix facilities of different departments within the same plan. There may be exceptions to this where a remote ambulatory clinic of one department is within the catchment area of an inpatient facility of another. Such an example might be Alaska where both Army and Air Force hospitals support nearby clinics of the other department. Overlapping catchment areas would be analogous to overlapping service areas of competing HMOs. Since the model is designed to encourage economic competition, it is expected that this will be an advantage.

This model is presented without regard to current legislative impediments and without an analysis of the additional management systems capability which would be required to implement it on a DoD wide basis. However, laws can be amended and the management systems required would be similar to those now used by several major managed care organizations. Given the expected interaction between the three military departments, full implementation of this model can only be accomplished on a DoD wide basis; especially with regard to the enrollment and financing systems.

Another important concern is that of the so called "ghost" beneficiary population. These are people who are

eligible for benefits but have chosen not to use the military system or CHAMPUS. Generally these people have obtained insurance coverage or joined HMOs through their employers and find it more convenient to participate in the health benefits plan than fight the access problem in the military system or the paperwork required to receive CHAMPUS reimbursement. Increasing access to military facilities may well cause some of these beneficiaries to reconsider their decision. In addition, due to the rapidly escalating costs, many employers are making efforts to shift more of the cost of health coverage onto the individual employees. That, in itself, may cause substantial numbers of "ghosts" to return to the military system, whether or not access is improved. This is an unknown but should not cause health care policy makers to decide to retain the currently restricted access. In fact, if that were the policy response, most of the returnees who are under 65 years of age would be forced to use the more expensive CHAMPUS option, thereby further increasing the cost to the government.

As mentioned earlier, the current military model resembles an open ended or point of service HMO. The proposed model does not depart from this basic design, but restructures the enrollment and financing systems to provide each catchment area manager with the appropriate

incentives to provide necessary care in a cost effective manner. In addition, it reorganizes primary care delivery to provide more access and continuity of care to all beneficiaries who want to have their own physician. It also introduces a formal utilization management program to be implemented in each catchment area.

Although the model could be implemented partially, it is a synergistic model in which each part depends on the others for maximum effect. For example, implementation of a formal utilization management program without capitation payment would severely reduce its effectiveness.

The model could easily be demonstrated by expanding current catchment area management demonstration projects or by initiating additional demonstrations in other selected catchment areas.

Currently, former Public Health Service hospitals, called Uniformed Services Treatment Facilities (USTF), are authorized under contract to provide services to all eligible DoD beneficiaries. Some of the USTFs are located close to DoD facilities with beneficiaries using both. The USTFs should be required to participate fully as catchment area health plans, or be dropped from the current program. If any of these facilities choose not to participate, beneficiaries living exclusively in that facility's catchment area will enroll in CHAMPUS to receive benefits.

SECTION B. MANDATORY ENROLLMENT

At present, all beneficiaries of the military health care system are enrolled in DEERS. It appears as one giant HMO with nine million worldwide members. Any of the members can access the HMO at any of its clinics around the world. No commercial HMO would be able to adequately manage such a cumbersome arrangement. Each beneficiary will be required to enroll in a specific catchment area plan. The only requirement, other than eligibility, is that the beneficiary reside within the plan's catchment area. Failure to enroll in a specific plan will result in the withholding of all benefits; use of the military direct care system and CHAMPUS coverage, if eligible. Beneficiaries who do not reside in any catchment area will be enrolled in CHAMPUS. With enrollment, catchment area managers will be able to better plan and execute their programs and budgets.

With mandatory enrollment there may be some shifting of beneficiaries from one military department to another compared to the current allocation. This may occur in those areas with overlapping catchment areas. Currently beneficiaries in close proximity to more than one medical facility tend to shop for the most convenient and available service. For example, in the Washington, DC area they have a choice among three department's tertiary care medical

centers, two Army community hospitals and numerous ambulatory care clinics including the contracted PRIMUS clinics. Requiring each beneficiary to enroll in only one plan may tend to change the current distribution. Beneficiaries will be required to access only the plan in which they have enrolled; however, they may be referred to providers in other plans by their own plan. Once enrolled, beneficiaries cannot change plans for at least one full year unless they move their residence out of the plan's catchment area. Beneficiaries who enroll in a participating USTF will be required to obtain all routine care from that facility.

Beneficiaries enrolled in CHAMPUS due to their residence location will be able to access care at a military medical facility without referral.

Each medical facility should maintain the capability for enrolling beneficiaries on an open basis. When an otherwise eligible, but non-enrolled, patient presents himself or herself for care, enrollment should be accomplished simultaneously. Patients who are enrolled in other catchment area health plans should be queried as to the circumstances of their visit. If they have permanently moved into the catchment area, or expect to be there for a period exceeding 120 days, enrollment should be

accomplished immediately by transfer from the previous plan.

All enrollees will maintain an enrollment card which will have a programmable magnetic strip identifying the home plan. In addition, the DEERS data base will include a code which will indicate each eligible beneficiary's plan membership.

SECTION C. FINANCING

For each catchment area plan the principal method of financing is by capitation. This is a major departure from the current method which is based upon workload accomplished. Based upon the ages and sex of the plan enrollees, as of the beginning of each month, payment will be provided to the catchment area manager. The plan will be responsible for all necessary and appropriate medical care for enrolled beneficiaries including that care which beneficiaries arrange for themselves or children under CHAMPUS. Care not available within the resources of the medical treatment facility will be arranged by the plan to be provided by civilian providers, other federal hospitals, or by other military facilities. For example, care not available at Fort Lee, Virginia can be referred to Walter Reed Army Medical Center, the nearby Veterans Hospital or a local civilian provider. The plan would be required to reimburse the provider for the care. In the case of the civilian provider, the plan may negotiate the fee prospectively or pay the billed charges. For government facilities, DRG and AVG based fee schedules will have to be developed as the current global per diem and clinic visit rates will not be adequate to reflect actual costs of care. Medical care provided beneficiaries enrolled in the catchment area plan will be reimbursed by the plan

manager whether the care was received from civilian providers or other military catchment area providers. Care obtained from civilian sources will be subject to CHAMPUS deductibles and copayments with CHAMPUS coverage rules applying.

Catchment area plans will also receive financial resources by treating non-plan beneficiaries. In many cases there will be referrals from other military catchment areas. It is expected that a significant proportion of the resources earned by tertiary care facilities will be through referrals from other plans. However, catchment plan managers may also choose to refer their patients to civilian sources of tertiary care if it is more cost effective. This will help to assure that to remain competitive military tertiary care commanders must effectively control their costs.

For medical treatment provided to those eligible beneficiaries who are not plan members (they must be enrolled in either another catchment area or in CHAMPUS) the plan providing care will be reimbursed by the beneficiary's plan. In the case of those who are enrolled in CHAMPUS, the corporate headquarters which manages CHAMPUS funding (Health Services Command in the case of the Army) will directly reimburse the catchment area plan which provided the care. Reimbursement for Medicare

beneficiaries could be a problem unless alternative financing arrangements can be made with HCFA. In the absence of some type of reimbursement from HCFA, medical care provided to Medicare beneficiaries who reside outside of all catchment areas can be reimbursed by the respective military departments based upon the fee schedule. Assuming no major changes in demand from such beneficiaries, the current medical budget includes the resources for this care. Possible solutions for qualified veterans and Medicare beneficiaries will be discussed below in Chapter Two.

Beginning the month following enrollment the local plan will receive capitation payments for each patient enrolled based upon the age and sex of the beneficiary. For active duty families, changing plan enrollment will often be a function of their personnel processing. The number of transactions resulting from permanent changes of station, extended temporary duty assignments, naval deployments with family members returning home is likely to be considerable. In some cases the change in location of the beneficiary will not be known until medical care is sought. This is particularly true concerning the retired beneficiary and his or her family members.

Not all of the costs of a military medical facility are attributable to medical care. The cost of maintaining

combat readiness and of supporting contingencies around the world must be separately budgeted. A certain amount of personnel time and other resources must be spent to assure worldwide deployability of military medical personnel. In addition, contingencies require the temporary assignment of medical personnel out of the catchment area requiring the commander to purchase alternative medical services for the plan beneficiaries. One recent example has been the continuing military presence in Honduras for which military medical personnel are required. Catchment area plans are tasked by their headquarters to provide providers with specific specialties as well as medical support personnel. Within the Navy, fleet deployments require physicians and corpsmen to leave the shore based medical facility and embark for months at a time. Also, many catchment area plans conduct graduate medical education and training for various medical specialties. These essential activities must also be separately resourced.

Essentially, catchment area plans will be resourced in three ways for medical care; (1) a monthly capitation payment based upon the enrolled population, (2) reimbursements for services provided to eligible beneficiaries who are enrolled in other plans or receive care under certain statutory provisions, and (3) budgeted costs of required military readiness and education and

training activities. This does not include the resourcing for other assigned missions (e.g. dental care, veterinary support) which will be budgeted as they are at present.

As with any HMO, there will be medical cases which entail extraordinary costs which would overwhelm the catchment area plan. This is handled by HMOs through the purchase of re-insurance from carriers who write a great amount of such coverage. At present, the three departments are essentially self insured for such catastrophic costs. The departments will continue to provide such coverage to the individual plans based upon an actuarial formula. This is very similar to the current catastrophic supplemental care readjustments made by the Army's Health Services Command to the budgets of its subordinate medical activities.

In order to adequately control CHAMPUS expenditures within a catchment area, managers must be able to match referrals to claims. This is currently not convenient with CHAMPUS claims being submitted by the provider directly to fiscal intermediaries outside the control of the catchment area manager. If the plan manager is financially responsible for out-of-plan use of medical providers, he must be able to control reimbursement. In addition, as will be discussed later, utilization management of ambulatory care provided under CHAMPUS will require local

review of provider claims on a retrospective basis.

SECTION D. COPAYMENTS AND DEDUCTIBLES

The current legislated CHAMPUS copayments of 20% and 25% appear to be in line with indemnity health plans in the United States. Open option HMO plans have copayments which range up to 30%. Attempts to increase the copayments for the out-of-plan CHAMPUS option above those levels could increase the risk of malpractice if it is considered to be too great of a barrier to the beneficiary. Higher copayments are also not needed when the plan maintains a reasonable network size.³⁴

Although the CHAMPUS copayments are within current norms, the deductibles are not. The current deductibles of \$50 per year for each individual and \$100 per year for each family were established in 1956 when military compensation was considerably lower. Although several efforts have been made to adjust these, opposition has been strong within the Department of Defense and among the various associations representing military families and retirees. Any discussion of this is considered an erosion of benefits to the military member and retiree. As it exists the current deductible is not an adequate deterrent to selecting the out-of-plan option and must be adjusted. The recent contract between Allied-Signal and Cigna established open ended plans across the nation for Allied-Signal employees. In order to provide equity the contract

calls for a deductible which is determined by the employee's salary.³⁵ A similar method can be used within the Department of Defense. The new deductibles would then be consistent with the beneficiary's salary or retired pay and would remain so despite pay increases. Although the Allied Signal deductible is considerably higher, a deductible of .5% of base pay per individual and 1% of base pay per family would raise the deductible sufficiently to help to deter overuse of the CHAMPUS option. To put this in perspective, the proposed deductible for an Army Specialist at pay grade E4 with two years of service will be \$57 per individual and \$113 per family. The deductible for a Colonel with 26 years of service will be \$303 per individual and \$606 per family. Those who retire at 50% of their base pay will see their deductible cut in half. The current deductible can be maintained for those few beneficiaries who receive no military pay or retired compensation. As of a particular month each year the deductible will be calculated for every eligible beneficiary and provided to the fiscal intermediaries. This can be done by multiplying the current monthly base pay of each individual by twelve and applying the percent. The department's military and retired pay offices should be able to provide a tape by social security number which could be posted to the DEERS data base.

Copayments (or user fees) for care provided in military facilities has been a recurring proposal. As in approximately half of the federally qualified HMOs, the military departments collect no fee at point of service for ambulatory care. A minimal per diem is collected from many beneficiaries for inpatient care. Several studies have been completed which demonstrate a reduction in medical care demand with the imposition of copayments. Some argue that copayments deter patients from obtaining needed care which may then increase the overall cost as well as place the patient at additional risk. It is generally accepted, however, that a small copayment will not significantly deter a patient and may well conserve the costly time of providers. The model will require a copayment of five dollars per visit to the clinic. A higher copayment of ten dollars for the use of the emergency room may also be considered. Subsequent provider encounters initiated by the provider may be exempt.

The institution of a copayment will most definitely be met with opposition. However, if the result is increased access for beneficiaries, the opposition can be muted. If this represents too great an erosion of military benefits for low ranking individuals, exemptions can be made by rank and annual maximum out-of-pocket costs can be established. Another possible answer is the establishment of a medical

allowance to be added to the military pay in much the same manner as the uniform allowance. This allowance should be based upon the size of the family. If the copayment is accompanied by a considerable increase in access to primary care, it may be more palatable to both active duty and retired families.

SECTION E. PRIMARY CARE DELIVERY

Changing the method of delivering primary care to eligible beneficiaries is the key to the success of the model. A successful open ended prepaid product must be characterized by reasonable and timely access as well as an adequate financial deterrent to exercise the open CHAMPUS option. In many cases, the present military system does the exact opposite; making access to primary care difficult and the open option relatively inexpensive with its low deductibles. Therefore, along with the above increase in CHAMPUS deductibles, access to care in the military direct care system must increase.

In order to accomplish this, additional primary care provider time must be found while at the same time demand for primary care must be reduced. As suggested earlier, current demand by active duty family members is a function of the following; (1) removal of the family from its traditional support structure, i.e. parents, close friends, etc., (2) the understanding that "free" health care is a benefit of the military life, and (3) the policy of providing "free" non-prescription drugs to beneficiaries.

Many minor illnesses tend to be self limiting. With treatment of the symptoms and time the body's defense mechanisms overcome the illness and the individual returns to full functioning. In many cases an individual will

consult a friend or close family member and follow their advice. If the symptoms linger or become worse, the doctor is called. In the absence of such a support system, the military general outpatient clinic is the common initial source of help. In most cases, a telephone call to the clinic will reach an appointments clerk or receptionist. Few clinics have procedures for patients to be able to receive medical assistance over the telephone. Because of this, the patient is almost always told to come to the clinic to be seen by a physician. In addition, those beneficiaries who are familiar with their symptoms and feel they need only to obtain non-prescription drugs to treat the symptoms also come to the clinic. Although aspirin, throat lozenges, and other such items are free; in most facilities they can only be obtained with a prescription from the PCP, PA, or nurse practitioner. Through this system, we overutilize the primary care provider (PCP) the most costly personnel asset we have.

Besides the introduction of the nominal five dollar copayment this model would cease providing non-prescription drugs to beneficiaries. These drugs are available at reasonable prices in military exchanges. As is done in many HMOs, the military pharmacies could carry these items for sale to the beneficiaries at a competitive price so

that patients could obtain these items when they have their prescriptions filled.

Finally, registered nurses will be used in the role of advice or triage nurse in the primary care setting. In some military facilities this is done in pediatric clinics to answer questions from parents. All patients will be encouraged to call the clinic if they need medical help. Using protocols, clinic clerks receiving calls from patients will determine if the call is for a routine appointment, acute minor illness, or an emergency. Based upon the protocol, the clerk will provide an appointment or refer the caller to an advice nurse. If the advice nurse is on the telephone to another patient, the patient will be called back by the nurse within a short time.

Advice provided over the telephone is documented, reviewed by the clinic chief on a regular basis, and posted to the patient's outpatient record. The advice nurse may advise the caller to report to the laboratory for tests depending upon the situation. A specific number of PCP appointments will be reserved for use only by the advice nurse. In that way, patients can be offered same day appointments if the situation warrants it. If an appointment cannot be provided within the required time, based upon medical necessity, the advice nurse will refer the patient to an alternative source of care within the

catchment area. With adequate staffing of primary care, this should be a very rare occurrence.

In many ways the use of the advice nurse is similar to the former use in the Army of the AMOCIST, a specially trained medical technician who treated patients for acute minor illness using a well developed algorithm. AMOCISTS worked in general outpatient clinics under the direction of physicians. Although the AMOCIST met the patient face to face, most of the information exchanged was verbal. With the increase in availability of physicians, this program was terminated. Based upon education and experience, the use of a registered nurse in this role is clearly superior.

Although the above actions will reduce demand for PCP time by reducing the number of patients physically entering the primary care clinic, additional provider time is needed. In order to increase PCP availability, general internists will begin providing primary care. Currently, access to internal medicine is through the general outpatient clinic. Patients with chronic medical problems must initially be seen in the primary care clinic and are then referred to the internal medicine clinic. Subsequent visits for these patients are often to different internists with no continuity of care. Many such patients now opt to

use CHAMPUS so that they can return to a doctor who is familiar with their case.

A Department of Primary Care will be organized which will include a General Outpatient Service, Troop Medicine Service, Family Practice Service (if available), Internal Medicine Service, and Pediatric Service. Beneficiaries who are not engaged in short term military training will be offered the opportunity to select a physician from among those within the department. Adults may select an internist, families may select a family practitioner, and children can be assigned a pediatrician based upon their parents choice. Those who do not wish to choose a physician will be assigned a clinic through which they will receive their primary care. All care will be coordinated by the primary care physicians for their patients. This will include specialty and ambulatory care, surgical procedures and required tertiary care. Patients will be required to initially access the system through the primary care clinic they have selected. Advice nurses can divert patients to other primary care clinics if care is not reasonably available at the assigned clinic.

Upon completion of the current contracts, PRIMUS clinics under the control of the catchment area commander will be reorganized under the same concept. Enrollees may select a PRIMUS clinic and then be required to obtain all

of their primary care at that clinic. These contracts should then be awarded on a capitation basis. This does not preclude the commander from using PRIMUS for "after hours" care on an area basis. For those patients who are not enrolled with the PRIMUS clinic the contractor can be reimbursed on a fee-for-service basis. All follow-up care would be returned to the patient's primary physician and/or clinic. Advice nurses, operating on a 24 hour basis, can direct patients to such a PRIMUS clinic if care is necessary before the next normal duty day.

The commanders must staff their facilities with an adequate number of primary care providers and the requisite support staff. Based upon accepted managed care standards, many Army medical care facilities are currently staffed at close to the required number of providers. Several exceed the number required. By applying these standards to the population supported, several selected Army catchment areas were analyzed and are presented in Appendix A. The data presented in Appendix A represents the population which can be supported by each of the Army catchment areas assuming each primary care provider can provide care to the managed care standard of 1600 people. In addition, it is assumed that each primary care nurse practitioner and physician's assistant can augment the PCP's capability by 800 people. Based upon information gathered from the six HMOs examined,

physician extenders spend more time with each patient and therefore can handle about one half of the workload of a physician.

The data does not recognize any other activities in which the PCPs may be involved. Participation in training of medical residents and military readiness tasks are examples of activities which are not considered by managed care organizations when staffing their primary care clinics. Additional analysis is needed to determine the impact of such activities on military PCP capacities. Activities which are inherent in any medical group or hospital are comparable, however. Military physicians and civilian HMO physicians are both required to serve on hospital committees, participate in quality assurance activities and maintain competence through continuing medical education.

With the open option available to beneficiaries it is expected that a certain number will choose to use providers outside the military facility. Therefore, it is not necessary to staff for the total supported population. Even with a relatively high 1%/3% of salary deductible, the "opt out" rate experienced by Cigna in their contract with Allied-Signal averages 16.8 percent over all regions with a range from 6.5 to 32.6 percent.³⁶ Those beneficiaries who currently have satisfactory relationships with civilian

providers under CHAMPUS will not be eager to change unless the increased deductible is sufficiently high to cause them to return to the direct care system. More likely is a scenario in which active duty family members return to the military direct care system upon moving into a new catchment area with their military sponsors. Retired members and their families are not as likely to move as often and will be slower to return. Therefore, initially the catchment area plan may only need to provide primary care services for seventy or eighty percent of the enrolled population, gradually increasing capability as demand increases.

It has been well understood by the Congress as well as the military departments that the current staffing ratios between providers and support personnel is inadequate. Providers in many military facilities are burdened with tasks which could and should be accomplished by less costly support personnel. Given the change in operation discussed above, manpower studies must be conducted to determine the optimum staffing to support each catchment area plan's enrolled population. Probably the best benchmark will be HMOs which organize their primary care activities in a similar manner. With the primary care delivery system described above, adequate staffing of provider and support personnel, and a reduction of demand for medical care from

the enrolled population; each catchment area plan ought to be able to adequately manage the demand for health care in a cost effective manner.

SECTION E. UTILIZATION MANAGEMENT

The final aspect of this model is the implementation of a formal utilization management program. By reducing inappropriate inpatient and ambulatory treatment, resources will be freed to apply to necessary improvements in access. The utilization management program and standards will be applied to all medical treatment within the catchment area whether in the military facility, under contract or informal agreement, or under CHAMPUS. Although the medical staff of each facility could develop their own guidelines, it is more efficient for the Department of Defense to procure the guidelines and permit the military departments and the catchment area plans to modify them for their local use.

Utilization management will include precertification of all elective hospital admissions and high cost diagnostic and treatment procedures done on an ambulatory basis. For CHAMPUS cases this precertification will be done prior to the issue of a Statement of Non-availability. Concurrent review will be done on all hospital admissions in the catchment area, both military and civilian; although it is recognized that with DRG reimbursement excessive lengths of stay in civilian hospitals under CHAMPUS is not as much of a problem. The current contracts with the Peer Review Organizations will be continued for care provided

under CHAMPUS outside of all catchment areas. As with successful HMOs most of this activity will be accomplished by specially trained registered nurses under the supervision of a physician.

Case management programs will be expanded from the current demonstrations to all catchment areas. This activity can be accomplished in conjunction with pre-admission and concurrent review or as a separate department. The current hospital based discharge planning function will be expanded with the case manager following the identified patient throughout the whole continuum of health care.

The final utilization management activity centers around ambulatory care. Although this is now just emerging within the managed care industry, the military departments must begin now to develop this area. Several utilization management vendors already have automated programs which track patterns of ambulatory treatment among providers. All of these systems now rely on the information normally captured on a fee-for-service claims form. In the absence of a claims form, staff and group model HMOs have developed encounter forms which serve the same purpose. Those plans which have implemented ambulatory utilization management programs have been successful in identifying outliers in the use of diagnostic tests and pharmaceuticals. They have

also found the data to be very helpful in quality assurance. An encounter form will be needed to adequately implement this activity within military treatment facilities. Care provided by non-military facility providers on a fee-for-service basis can be monitored using claims forms. Claims adjudicated in the local area will contribute to the utilization management task. If claims continue to flow to distant fiscal intermediaries, the management of outpatient utilization will be complicated.

CHAPTER 2. THE MEDICARE PROBLEM

Although the model requires mandatory enrollment, some beneficiaries who enroll are not eligible for CHAMPUS. Those who are on active duty must either be provided care by the direct care military system or be referred to non-military providers with reimbursement by the catchment area plan. Also, those who are Medicare eligible are not covered by CHAMPUS. In 1986 nine percent of the total military health services system beneficiaries were 65 years of age or older with most of those Medicare eligible.³⁷ For care provided to these patients outside of the military treatment facility, reimbursement is provided by the Health Care Financing Administration. This then means that, if Medicare eligible beneficiaries are enrolled under capitation, the catchment area plan can easily shift the costs of providing care to Medicare beneficiaries from the lower cost military system to the fee-for-service civilian sector with Medicare paying the higher costs in total.

Actually, this is already a problem within the current catchment area management demonstrations. With each department now managing the total health care budget, and with military retired members and their families relegated to a lower priority for care on a space available basis, there is a strong financial incentive to shift the cost of

medical care for those beneficiaries from the Department of Defense to the Medicare Trust Fund.

There are two solutions to this. One is for HCFA to reimburse the Department of Defense for Medicare covered medical care which is delivered by military treatment facilities. Inpatient care should be reimbursed at cost using DRGs and reimbursement rates for ambulatory care can be negotiated between the two departments. Under this solution, DoD beneficiaries, who are also eligible for Medicare, would be capitated only for medical services not covered by Medicare (e. g. prescriptions). Medicare covered services provided by the military facility would be reimbursed by HCFA as is the care now provided in the fee-for-service sector.

A second solution is for HCFA to contract with the catchment area plans or with the military departments as Medicare Insured Groups (MIG) or as Competitive Medical Plans (CMP). The MIG program is currently in a demonstration phase under the direction of HCFA. Under either of these options, the catchment area plans would receive monthly capitation payments from HCFA and be responsible for all covered Medicare benefits for Medicare enrolled beneficiaries.

It is natural that HCFA would not wish to increase its outlays for Medicare at this time of severe budget

constraints. It would be appropriate for that portion of budget authority representing current DoD medical support to Medicare beneficiaries to be transferred from the Department of Defense to the Department of Health and Human Services. If that were accomplished, it would be to the benefit of HCFA to obtain the maximum amount of care for their enrolled beneficiaries in military facilities which are known to be able to provide the care at a lower cost to the government. If more of this care is provided within the military managed care model, the government will be sure to benefit from lower overall costs.

Some military health system beneficiaries are also beneficiaries of the Department of Veterans Affairs (DVA). These individuals have generally incurred service connected disabilities for which they may be treated by DVA facilities. Some may be eligible for medical care primarily due to their poor financial situation. It may be necessary to determine which department has primary responsibility for care for these dually eligible beneficiaries; however, this may not be a significant issue due to the number of those in this category. Should capitation be implemented for financing the catchment area plans, this issue may warrant further investigation.

PART IV. CONCLUSIONS AND SUMMARY

It has been apparent for the past several years that the health care cost issue is becoming more prominent on the list of the nation's most pressing problems. Within the military departments it has been exacerbated by reductions in the defense appropriations provided by the Congress. Just as the major employers in the United States are aggressively searching for solutions, even to the extent of advocating some form of national health insurance, the military departments, the Department of Defense and the Congress have been trying to develop programs which will reduce the impact of medical costs on the nation's defense expenditures.

While it is widely accepted that providing health care within the military direct health care system is generally more cost effective than the unmanaged fee-for-service sector, the appropriate structure and incentives have not been put into place to assure adequate progress toward increasing both the capability and effectiveness of direct care. Additional capability has often lead to increased utilization at a lower cost per unit of service but at a higher overall cost.

The military managed care model described above as the catchment area health plan will change the basic system of financing at the local level, reorganize the delivery of

primary care to promote better access and continuity, and institute much needed utilization controls to assure that care provided by any provider within the catchment area is necessary and appropriate. Through changes in copayments and deductibles the model will promote the use of the less expensive direct care alternative while maintaining the current beneficiary choice to seek ambulatory care outside the military direct care system. Through capitation financing, catchment area managers will be motivated to provide their enrolled beneficiaries with responsive, appropriate care and will be encouraged to develop well managed networks of providers to meet the needs of their enrollees.

In order to implement such a model current laws and regulations must be changed. Catchment area managers must be unhindered in choosing the best possible alternative for medical care. As an example, hotel accommodations should be covered by the plan for a child's mother when sending a child to a military tertiary care facility in a distant city

The current USTFs must fully participate in the catchment area health plan concept. They must agree to receive capitation payments and be willing to accept the open ended risk. If they cannot accept this at a

competitive capitation rate, they should not be permitted to participate except as standard CHAMPUS providers.

Using registered nurses in the function of utilization management and as primary care advice nurses represents a significant departure from the roles currently played by the military departments' nurse corps. It is recognized that there is currently a severe problem recruiting adequate numbers of nurses for the current functions. Again, current laws and regulations will have to be changed to permit catchment area plans to compete with utilization management firms, large employers and managed care organizations (HMOs, PPOs) in attaining those nurses.

A key requirement for success is the resolution of the question of financing for Medicare beneficiaries. Without an appropriate source of reimbursement, either a fee based or capitation arrangement, Medicare beneficiaries are likely to be shifted out of the military direct care system into Medicare fee-for-service. This will be detrimental to the beneficiaries and much more costly to all taxpayers.

APPENDIX 1

Primary Care Capabilities of Selected Army Catchment Areas Under Managed Care Model (1988)

	<u>Catchment Population</u>	<u>PCF Staff Capacity</u>	<u>% Pop. Supported</u>
Fort Bliss, TX	78,358	76,000	97
Fort Benning , GA*	74,830	79,880	107
Fort Bragg, NC*	131,355	117,200	89
Fort Campbell, KY	64,039	62,880	98
Fort Carson, CO	67,628	68,000	101
Fort Jackson, SC	48,541	36,800	76
Fort Polk, LA	39,359	54,880	139
Fort Stewart, GA*	52,698	61,820	117
Fort Devens, MA	55,295	31,800	58
Fort Eustis, VA	39,473	39,040	99
Fort Leavenworth, KS	35,855	29,600	83
Fort McClellan, AL	27,405	26,080	95
West Point, NY	26,119	25,760	99
Fort Gordon, GA	49,361	66,720	135
Atlanta, GA	32,148	24,000	75
Denver, CO	64,253	60,880	95
Fort Lewis, WA	129,394	108,800	84

	<u>Catchment Population</u>	<u>PCP Staff Capacity</u>	<u>% Pop Supported</u>
Fort Hood, TX*	110,149	117,480	107
Fort Knox, KY	61,750	52,800	86
Fort Leonard Wood, MO	32,016	53,760	168
Fort Riley, KS	44,250	49,120	111
Fort Sill, OK	58,064	65,920	114
Fort Wainwright, AK	20,227	12,800	59
Fort Huachuca, AZ	24,081	32,000	132
Fort Lee, VA	36,343	28,800	79
Fort Monmouth, NJ	61,083	26,880	44
Redstone Arsenal, AL	25,884	31,680	122
Fort Rucker, AL	32,884	50,720	154
Fort Drum, NY	18,975	27,200	143
Fort Irwin, CA	12,499	16,000	128
Fort Ben Harrison, IN	23,979	18,400	77
Fort Dix, NJ	57,338	45,920	80

*Support from PRIMUS Clinics is included

Note: Military unique duties and graduate medical education requirements not considered. PCP staff include physicians and physician extenders in pediatrics, internal medicine, family practice, general practice, and flight medicine

Source of data: US Army Health Services Command

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